Wisconsin Department of Regulation & Licensing

Mail To: **P.O. Box 8935**
Madison, WI 53708-8935
FAX #: (608) 261-7083
Phone #: **(608) 266-2112**

1400 E. Washington Avenue
Madison, WI 53703
E-Mail: web@drl.state.wi.us
Website: http://www.drl.state.wi.us

VERIFICATION OF LICENSURE

APPLICANT: Complete the top portion of this form and forward to the Board(s) in the state(s) in which you have ever been licensed. (This form may be copied.)

CHECK ONE: ☐ Registered Nurse ☐ Licensed Practical Nurse

NAME _____
(LAST) (FIRST) (MIDDLE) (MAIDEN/FORMER)

ADDRESS _____
(NO. & STREET OR P.O. BOX) (CITY) (STATE) (ZIP)

DATE OF BIRTH _____ _____ _____ ORIGINAL LICENSE # _____
(MONTH) (DAY) (YEAR) DATE ISSUED (YEAR)

NAME OF SCHOOL OF NURSING (NO INITIALS) _____

LOCATION _____
(CITY) (STATE) (COUNTRY)

I HEREBY AUTHORIZE THE _____ BOARD OF NURSING TO FURNISH THE WISCONSIN BOARD OF NURSING THE INFORMATION REQUESTED BELOW.

DATE _____ SIGNATURE _____

DO NOT WRITE BELOW THIS LINE

STATE BOARD: Please complete this section and submit it to the Wisconsin Board of Nursing at P.O. Box 8935, Madison, WI 53708.

NAME _____
(LAST) (FIRST) (MIDDLE) (MAIDEN/FORMER)

Original License Number _____

Date of Issuance (Month/Day/Year) _____

Check one:
☐ RN
☐ LPN

Licensed By:
☐ Examination
☐ Endorsement
☐ Waiver

Was the examination in English?
☐ Yes ☐ No

Current Licensure Status:
☐ Active
☐ Inactive
☐ Lapsed

Has this license ever been encumbered (revoked, suspended, surrendered, restricted, limited, placed on probation, etc.) in any way?
☐ Yes ☐ No If yes, attach explanation and copy of the public documents.

SEAL

Signed: _____

Title: _____

State: _____ Date: _____

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Ch. 441, Stats.